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FISCAL IMPACT STATEMENT

LS 7525
BILL NUMBER: SB 472

NOTE PREPARED: Feb 9, 2009
BILL AMENDED:

SUBJECT: Medicaid Matters.

FIRST AUTHOR: Sen. Miller
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill provides that, beginning January 1, 2010, an individual who is receiving monthly assistance payments for the aged, blind, or disabled under the federal Supplemental Security Income (SSI) program and an aged, blind, or disabled individual who has a family income that does not exceed 200% of the federal income poverty level (FPL) is eligible for Medicaid. (Under current law, an individual receiving SSI disability payments must also meet the state's: (1) definition of disability; and (2) financial criteria.)

The bill requires the Office of Medicaid Policy and Planning (OMPP) to apply for a Medicaid waiver to allow OMPP to determine cost-sharing amounts for an individual with a disability whose family income is more than 75% of FPL and terminate the individual's participation in the Medicaid program if the individual does not pay the individual's cost share.

The bill repeals a supplemental hospital payment program for private, non-government owned hospitals and requires the Office of the Secretary of Family and Social Services (FSSA) to establish an enhanced payment program for hospitals that provide significant medical education or are critical needs hospitals.

The bill also authorizes OMPP to collect an assessment on hospitals that may not exceed 4% of the hospital's net revenue from the preceding fiscal year. It creates the Medicaid Hospital Assessment account.

The bill allows certain individuals to participate in the Healthy Indiana Plan (HIP) without state funding.

It also allows a nonprofit organization and certain health care insurers and health maintenance organizations to contribute to the health care account of a HIP participant under certain circumstances.

The bill specifies that the minimum amount paid by certain plan participants into the participant's health care account is $60.

The bill repeals the Hospital Care for the Indigent (HCI) Program beginning January 1, 2010. It also adds additional purposes for expenditures from the state HCI Fund to include HIP coverage of childless adults and the administration of state-operated facilities.

The bill requires OMPP to: (1) apply to the federal government to change the state's status regarding Medicaid and individuals who participate in SSI; (2) terminate the state's Medicaid spend-down program; and (3) increase Medicaid eligibility for individuals with a disability.

The bill repeals a provision requiring an annual General Fund transfer of $40 M to the Marion County Health and Hospital Corporation.

The bill repeals a provision allowing individuals to obtain health care coverage that is the same as the HIP if the plan has reached maximum enrollment using standard underwriting practices.

The bill requires the Secretary of Family and Social Services to report to the Select Joint Commission on Medicaid Oversight before September 1, 2009, on; (1) the status of the Disproportionate Hospital Share (DSH) program and any changes needed for the system; (2) the establishment of the enhanced payments for medical education and critical needs hospitals; and (3) the readiness for repeal under this act of the HCI Program on January 1, 2010.

It also makes technical changes.

Effective Date: Upon passage; July 1, 2009; January 1, 2010.

Explanation of State Expenditures: *Summary:* This bill would implement four major initiatives within the Medicaid program.

(A) Eligibility Revision for Medicaid Aged, Blind, and Disabled-
The bill would revise the state's status as a Medicaid 209(b) state to a 1634(a) status, which recognizes an SSI disability determination as eligibility for Medicaid and discontinues the spend-down requirement. OMPP has estimated the state cost of this part of the provision to be approximately $24.8 M and $52.3 M in FY 2010 and FY 2011, respectively. An increase in the aged, blind, and disabled population on Medicaid will have an unknown impact on the 100% state-funded burial assistance program for aged, blind, and disabled Medicaid recipients. Funding would be provided for this provision by the hospital assessment established in this bill; up to 30% of the hospital assessment may be used to fund the expansion of Medicaid eligibility for the aged, blind, and disabled. By electing the 1634(a) status, SSI eligibles would be fully eligible for Medicaid benefits with no need for a separate Medicaid application process or a spend-down calculation, eliminating the duplicative OMPP eligibility process and the need to administer the spend-down program.

The bill would also increase the income eligibility standard for the blind and disabled to 200% of the FPL. The bill would authorize OMPP to apply for a demonstration waiver to require cost sharing on a sliding fee scale for the blind and disabled population with incomes above 75% and below 200% of the FPL. The estimated state cost of the expansion of eligibility to 200% of FPL and the waiver is $15.7 M in FY 2010 and $47.9 M in FY 2011. Funding would be provided for this provision from two sources: (1) the hospital assessment, up to 30% of which may be used to fund the expansion of Medicaid eligibility for the aged,

blind, and disabled and (2) the repeal of the HCI program and the subsequent redistribution of federal DSH dollars.

(B) Hospital Assessments and Supplemental Payments-
The bill would impose a hospital provider tax based on net revenues to provide funding to increase Medicaid hospital reimbursement rates and to increase the income eligibility for the aged, blind, and disabled. Based on 2007 data, a 4% assessment was estimated to yield revenue in the range of $528.3 M to $552.2 M, depending on the definition of net revenue that is used. The bill would also discontinue the authority for hospital supplemental payments under the HCI program and the UPL hospital supplemental payment program.

(C) *Healthy Indiana Plan Expansion-*
The bill would repeal the HCI program and redirect the program funding to expand the Healthy Indiana Plan and to implement a supplemental hospital payment program for critical needs hospitals and medical education.

(D) The bill repeals a provision requiring an annual General Fund transfer of $40 M to the Marion County Health and Hospital Corporation.

Background Information-

(A) Eligibility Revision for Medicaid Aged, Blind, and Disabled-
209(b) Status: Effective January 1, 2010, the bill would require OMPP to amend the state Medicaid Plan to change the state's status from a 209(b) state to a 1634(a), or SSI, state. Once the status is changed, the 209(b) status cannot be reinstated. The 209(b) exclusion is a clause in the Social Security Act that allows more restrictive eligibility criteria to be used if they were in place in the state's Medicaid Plan as of January 1, 1972. In Indiana and 10 other states, this means that more restrictive criteria for Medicaid eligibility is used for the aged, blind, and disabled population than that used to determine eligibility for SSI. While Indiana uses the SSI definition of disability, the income and resource standards used are lower than those used by SSI. Medicaid Plan amendments are considered to be an administrative task that can be accomplished within the current level of resources available to the OMPP.

By eliminating the 209(b) status, the bill would increase the income eligibility for the aged, blind, and disabled from the SSI Federal Benefit Rate (FBR) (currently this is $674 monthly for a single person and $1,011 monthly for a couple) to the amounts allowed for SSI eligibility. The bill would increase the current state resource limit from $1,500 for a single person to $2,000; and from $2,250 for a couple to $3,000.

Effective January 1, 2010, the bill would also make blind and disabled individuals with incomes below 200% of the FPL who meet the medical criteria and the resource limits for SSI eligibility eligible for Medicaid. This group may not be on Medicaid or SSI for a variety of reasons.

Elimination of the 209(b) status would increase the number of aged, blind, and disabled individuals on Medicaid. OMPP has estimated that initially an additional 15,500 aged, blind, or disabled individuals would become eligible for Medicaid. The bill provides that up to 30% of the hospital assessment may be used to fund the expansion of Medicaid eligibility for the aged, blind, and disabled and the Healthy Indiana Plan.

An increase in the aged, blind, and disabled population on Medicaid will have an impact on the 100% state-

funded burial assistance program for aged, blind, and disabled Medicaid recipients. This program currently makes payments to funeral directors and cemeteries as defined in state statute. Expenditures were approximately $1.3 M in FY 2008. [FSSA has not supplied an estimate for the potential fiscal impact on this program.]

Elimination of the 209(b) status would eliminate the spend-down program. States that elected 209(b) status were required to implement a program for the medically needy to allow individuals who are otherwise eligible, to spend-down excess income to become eligible for Medicaid. If the state elects the 1634(a) status, SSI eligibles would be fully eligible for Medicaid benefits with no need for spend-down, eliminating the need to administer that program. [OMPP has not supplied an estimate of administrative cost savings associated with the elimination of the spend-down tracking process. This may now be a contractor expense with the savings occurring within the contract.] There were an average of 37,854 members per month that had spend-down obligations during FY 2008.

Elimination of the 209(b) status would allow Medicaid to discontinue duplicative administrative expenses. Indiana requires an application for Medicaid and does an eligibility determination separate from the SSI process. (The Indiana Medical Review Team currently conducts the medical eligibility determination for the Social Security Administration.) If the 209(b) status is changed, Medicaid eligibility would be determined simultaneously with the Social Security Administration's determination for SSI benefits. Medicaid applications might only be required for applications for long-term care or waiver services, or for individuals denied SSI due to excess income but otherwise eligible. [OMPP has not supplied an estimate of administrative cost savings associated with the elimination of the separate eligibility determination process.]

Demonstration Waiver: The bill would authorize OMPP to apply for a demonstration waiver to require cost sharing on a sliding fee scale for the aged, blind, and disabled population with incomes above 75% and below 200% of the FPL. The demonstration waiver would apply to the entire aged, blind, and disabled population: the current recipients and any additional recipients added through the provisions of the bill. The bill provides that if an individual's cost sharing payment is not received within a specified period of time from the due date, the individual may be terminated from the Medicaid program. The bill specifies that once terminated from Medicaid, the individual may not reapply for Medicaid benefits for 12 months. The fiscal impact of this provision would depend on federal approvals and actions taken by the administration. Medicaid waiver development is considered to be an administrative task that can be accomplished within the current level of resources available to the OMPP.

Background Information on SSI Eligibility: During an initial SSI eligibility determination, the Social Security Administration looks at the individual's medical status and ability to engage in substantial and gainful activities (SGA). If a disabled individual has earned income below $980 per month with certain exceptions, the individual may be determined to be eligible for SSI disability. After an initial eligibility determination, an individual is encouraged to work if possible. SSI disregards the first $20 of earned or unearned income, the first $65 earned from working, and one-half of the amount earned over $65. SSI also does not count wages used to pay for items or services needed to help the individual engage in work activities. When countable earnings reach $1,433 per month, no benefit will be paid although the individual may still be eligible for SSI and Medicaid. (Higher income criteria are used for individuals that are blind.) After two years on SSI, a disabled individual becomes dually eligible for Medicare and Medicaid. Medicaid covers premiums, copayments, and deductibles, as well items or services that may not be covered by Medicare for the dually eligible. Working individuals also may have health insurance but may also keep Medicaid to cover items not covered by private insurance.

Background Information on Income Eligibility Levels:

Table of Monthly Income Standards						
Household Size	**100% SSI* FBR**	**75% FPL#**	**SSI SGA**	**100% FPL**	**200% FPL**	**300% SSI**
1	$ 674	$ 650	$ 980	$ 867	$ 1,734	$ 1,911
2	$ 1,011	$ 875		$ 1,167	$ 2,334	$ 3,033
Federal Benefit Rate (FBR), Federal Poverty Level (FPL), Substantial Gainful Activity (SGA).						

Table of Annualized Income Levels						
Household Size	**100% SSI*FBR**	**75% FPL#**	**SSI SGA**	**100% FPL**	**200% FPL**	**300% SSI**
1	$ 8,088	$ 7,800	$ 11,760	$ 10,400	$ 20,800	$ 24,264
2	$ 12,132	$ 10,500		$ 14,000	$ 28,000	$ 36,396
* SSI benefit information is for Calendar Year 2009. # FPL information is for Calendar Year 2008.						

(B) Hospital Assessment and Supplemental Payments

Increased Hospital Medicaid Reimbursement Rates-
The bill provides the hospital assessment as a funding mechanism for increased Medicaid hospital reimbursement rates. The amount of an increase in the Medicaid hospital reimbursement rate would depend on actions taken by OMPP.

Increased Medicaid hospital reimbursements would impact state programs that are required to use Medicaid reimbursement rates for hospital services. Programs affected would include Assistance for Residents of County Homes (ARCH), the 590 Program, and the Children's Special Health Care Services Program. The ARCH program provides 100% state-funded medical assistance to residents of county homes. The benefits of the program are identical to those offered by Medicaid, and the program is included in the Medicaid budget. Currently, the ARCH program is projected to require $4.8 M in FY 2010 and FY 2011 according to the December Medicaid Forecast. The 590 Program provides medical assistance to residents of state-operated facilities that must be provided in hospitals outside the institutions. This population is generally excluded from Medicaid, and required hospital services that cannot be provided within the institution are paid for with 100% state funds. The Children's Special Health Care Services program provides services to children under the age of 21 who do not qualify for Medicaid, but do meet the program's medical criteria and are in families with incomes below 250% of the FPL. Individuals with cystic fibrosis have lifetime coverage under this program. The extent of the fiscal impact on these three programs that would result from a hospital reimbursement rate increase is not known at this time.

Hospital Supplemental Payment Programs-

Upper Payment Limit: The bill repeals a supplemental hospital payment program for private, nongovernment-owned hospitals.

Hospital Care for the Indigent (HCI) Supplemental Payments-
The bill repeals the Hospital Care for the Indigent program beginning January 1, 2010. The repeal includes

HCI supplemental payments to hospitals, as well as HCI payments made to emergency transportation providers, and physicians. HCI funds are currently used to leverage federal Medicaid funding via the Medicaid Indigent Care Trust Fund. (Previously funded by a county welfare levy, the HCI levy was assumed by the state in HEA1001-2008.) The bill also adds additional purposes for expenditures from the state HCI Fund to include HIP Program coverage of childless adults and the administration of state-operated facilities.

Medical Education and Critical Needs Supplemental Hospital Payments: The bill requires FSSA to establish an enhanced supplemental payment program for hospitals that provide significant medical education or are critical needs hospitals.

(C) Healthy Indiana Plan Expansion-

HIP Expansion: Contingent upon legislative approval of an additional funding source and the shift of capped federal DSH funding, the bill would allow for an expansion in the number of caretaker and childless adults covered under the Healthy Indiana Plan. The size and extent of any expansion would be contingent upon the action of the legislature. Federal approval of a waiver amendment to expand the HIP program and the funding mechanism would also be required. The bill would provide that up to 30% of the hospital assessment may be used to fund the expansion of Medicaid eligibility for the aged, blind, and disabled and the Healthy Indiana Plan.

HIP Minimum Contribution: The bill would require a minimum contribution of $5 per month from all participants in the HIP program. Currently, approximately 14,000 individuals with incomes below 100% of the FPL are exempted from making sliding scale-based payments into their health savings account. This provision would result in annual health savings account deposits of $840,000 being made by participating individuals rather than the state.

Unsubsidized Participation in HIP: The bill would allow an otherwise qualified individual to participate in the HIP coverage with no state subsidy, either because the program has reached maximum enrollment or the individual has too much income. Under this HIP option, the plan would not include the $500 of state-provided qualifying preventive care services. The bill would require that individuals participating under this option contribute $1,100 to the individual's health care account and any other costs associated with participation in the HIP program.

HIP Assistance or Incentives: The bill would allow a not-for-profit organization that is not affiliated with a health care plan to contribute up to 50% of an individual's required premium payment. This provision would allow not-for-profits to provide some assistance to HIP enrollees either on a temporary or long-term basis. The bill would also allow an insurer or managed care organization contracted with the OMPP to provide rewards as incentives. The bill specifies that the incentives cannot be given to induce an individual to receive services from a particular health care provider or facility. Rewards must be deposited in the individual's health care account, or if the account is fully funded, it may be provided directly to the individual.

Additionally, insurers or health maintenance organizations that contract with the OMPP to provide coverage under HIP are prohibited from distributing information or materials related to a specific health care provider or facility to an eligible individual or participant.

Explanation of State Revenues:

(B) Hospital Assessment and Supplemental Payments-

The bill would allow OMPP to assess a licensed hospital 4% of the hospital's total annual net revenue for the preceding year. According to the State Department of Health (ISDH) website, the bill would assess approximately 143 licensed hospital facilities: 90 short-term hospitals, 35 critical access hospitals, 12 long-term care hospitals, and 6 rehabilitation hospitals. (Psychiatric and developmental disability hospitals are excluded from the assessment.) The bill does not define the term "total annual net revenue". Using the 2007 Hospital Fiscal Report data collected by ISDH, a 4% assessment would yield $528.3 M if assessed on patient service revenue net of contractual allowances and other deductions. An assessment on net patient service revenue and other operating revenue or total operating revenue would yield $552.2 M. These estimates should be considered conservative since the ISDH data is missing fiscal reports from 21 licensed facilities, including several new proprietary facilities, Methodist Hospitals, and St. Anthony Hospitals. Additionally, the data is based on the hospital fiscal years which may reflect 2006 or 2007 data. The estimated assessment revenue is not adjusted to reflect higher revenues in 2008 or 2009.

Monies collected from the Hospital Assessment would be deposited in the nonreverting Medicaid Hospital Assessment account, created by the bill. Money in the account is restricted to payment for services for which federal financial participation is available. The bill requires that 70% of the Hospital Assessment must be used to provide Medicaid hospital services and hospital reimbursement rate increases. The remaining 30% of the Assessment fund may be used to fund Medicaid coverage for the aged, blind, and disabled and for HIP. The bill provides for a termination of the assessment if federal law would discontinue the availability of the federal matching funds.

(Under the Federal Economic Stimulus Plan, federal enhanced FMAP will be available for regular program expenditures such as reimbursement increases but not for DSH. The DSH caps would be increased by 2.5% for FFY 2009 under the Economic Stimulus Plan.)

(A) Eligibility Revision for Medicaid Aged, Blind, and Disabled-

MEDWorks Impact: The expansion of eligibility for the aged, blind, and disabled to 200% of the FPL would also impact the amount of premium revenue collected from disabled individuals participating in the MEDWorks program. The Medicaid forecast identifies $1.7 M in MEDWorks premiums collected annually. The increase in the income standard would be anticipated to decrease the amount of premiums collected from working individuals with incomes between 150% and 200% of the FPL. The number of individuals and the associated premium revenue is unknown at the time. [This information will be added when it is available.]

Demonstration Waiver Cost Sharing: The bill would authorize OMPP to apply for a demonstration waiver to require cost sharing on a sliding fee scale for the aged, blind, and disabled population with incomes above 75% and below 200% of FPL. Cost-sharing amounts would be determined by OMPP subject to federal approval. Cost sharing would probably be similar to premium levels established within the existing HIP program. If a waiver is approved, it could result in a shift of premium revenue from the MEDWorks program to the waiver program. The increase in the Medicaid income eligibility standard would be anticipated to decrease the amount of premiums collected from working individuals with incomes between 150% and 200% of the FPL who are currently participating in the MEDWorks program. The revenue shift would depend on the level of the cost sharing established under the waiver. The number of affected MEDWorks participants and the associated premium revenue is unknown at the time. [This information will be added when it is available.]

Explanation of Local Expenditures: *(B) Hospital Assessment and Supplemental Payments-*
Local government-owned hospitals would be required participate in the hospital assessment.

(A) Eligibility Revision for Medicaid Aged, Blind, and Disabled-

209(b) Status: The increase in the numbers of SSI beneficiaries eligible for Medicaid and the elimination of spend-down requirements may have an impact on township poor relief by decreasing the number of requests for assistance due to lack of Medicaid coverage, requests for assistance due to current Medicaid spend-down requirements, and requests for burial assistance. The extent to which the bill might decrease requests for township assistance is indeterminate.

Explanation of Local Revenues: *(D) Repeal of HEA 1001-2008 Provision-*
The bill repeals a provision requiring a state payment of $40 M to be made to the Marion County Health and Hospital Corporation for property tax relief.

(B) Hospital Assessment and Supplemental Payments-

Increased Hospital Medicaid Reimbursement Rates: Local government-owned hospitals would participate in any increased Medicaid reimbursement rates.

State Agencies Affected: OMPP; FSSA; ISDH.

Local Agencies Affected: Local government-owned hospitals; Township trustees; Marion County Health and Hospital Corporation.

Information Sources: FSSA, Social Security Administration.

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